4. PROGRAM REGULATIONS

402.401: Introduction

(A) The regulations in 130 CMR 402.000 state the requirements and procedures for the purchase of vision care services under MassHealth. Vision care services are the professional care of the eyes for purposes of diagnosing and correcting refractive errors, analyzing muscular anomalies, and determining pathological conditions. They include eye examinations, vision training, and the prescription and dispensing of ophthalmic materials. Professional and technical services must be provided in accordance with the established standards of quality and health-care necessity recognized by the vision care industry and licensing agencies in Massachusetts.

(B) All vision care providers participating in MassHealth must comply with the regulations of the Division governing MassHealth, including but not limited to Division regulations set forth in 130 CMR 402.000 and 450.000.

402.402: Definitions

The following terms used in 130 CMR 402.000 shall have the meanings given in 130 CMR 402.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 402.402 is not determined by these definitions, but by the application of regulations elsewhere in 130 CMR 402.000 and in 130 CMR 450.000.

Dispensing Practitioner — any optician, optometrist, ophthalmologist, or other participating provider authorized by the Division to dispense eyeglass frames, lenses, and other vision care materials to members.

Optical Supplier — the optical laboratory contracted by the Division to supply the following ophthalmic materials and services:

(1) eyeglass frames;
(2) eyeglass lenses;
(3) frame cases;
(4) tints, coatings, ground-on prisms, and prisms by decentration; and
(5) repair parts.

Order — the process by which a dispensing practitioner requests ophthalmic materials (completed eyeglasses, repair parts, and other services) from the optical supplier.

Order Form — the form used by the dispensing practitioner to request ophthalmic materials (completed eyeglasses, repair parts, and other services) from the optical supplier. The required form is specified in the billing instructions in Subchapter 5 of the *Vision Care Manual.*

Prescriber — any optometrist, ophthalmologist, or other practitioner licensed and authorized to write prescriptions for eyeglass frames, lenses, and other vision care services.

402.403: Eligible Members

(A) (1) MassHealth Members. The Division covers vision care services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the Division's regulations. The Division's regulations at 130 CMR 450.105 specifically state, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

(2) Age Limitations. In addition to any other restrictions and limitations set forth in 130 CMR 402.000 and 450.000, the Division covers the following services only when provided to eligible MassHealth members under age 21: ophthalmic materials, specifically including, but not limited to, complete eyeglasses or eyeglass parts; the dispensing of ophthalmic materials; contact lenses; and other visual aids, except that this age limitation does not apply to visual magnifying aids for use by members who are both diabetic and legally blind. Visual magnifying aids do not include eyeglasses or contact lenses.

(3) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106.

(B) For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

402.404: Provider Eligibility

Payment for services described in these regulations will be made only to providers of vision care services who are participating in MassHealth on the date of service. The eligibility requirements for providers of vision care services are as follows.

(A) In State.

(1) Optometrists. A Massachusetts optometrist is eligible to participate in MassHealth only if licensed to practice by the Massachusetts Board of Registration of Optometrists.

(a) A Level I optometrist is one who is not qualified to apply topical agents.

(b) A Level II optometrist is one who has completed the required course of study and passed the examination necessary to obtain certification to apply topical agents.

(c) A Level III optometrist is one who is certified to prescribe, dispense, and administer therapeutic pharmaceutical agents (TPA) for abnormal ocular conditions and diseases.

(2) Opticians. A Massachusetts optician is eligible to participate in MassHealth only if licensed to practice by the Massachusetts Board of Registration of Opticians.

(3) Ophthalmologists. A Massachusetts ophthalmologist is eligible to participate in MassHealth only if licensed to practice by the Massachusetts Board of Registration in Medicine. Ophthalmologists are governed by these regulations only with respect to the dispensing of ophthalmic materials. All other vision care services provided by ophthalmologists must be in compliance with the physician regulations of MassHealth.

(4) Ocularists. A Massachusetts ocularist is eligible to participate in MassHealth only if certified by the National Examining Board of Ocularists.

(B) Out of State.

(1) Optometrists. An optometrist located outside of Massachusetts is eligible to receive payment for vision care services provided to Massachusetts members only if the optometrist is licensed to practice by the appropriate state's board of registration.

(2) Opticians. An optician located outside of Massachusetts is eligible to receive payment for vision care services provided to MassHealth members only if the optician is licensed to practice by the appropriate state's board of registration.

(3) Ophthalmologists. An ophthalmologist located outside of Massachusetts is eligible to receive payment for vision care services provided to MassHealth members only if the ophthalmologist is licensed to practice by the appropriate state's board of registration. Ophthalmologists are governed by these regulations only with respect to the dispensing of ophthalmic materials. All other vision care services provided by ophthalmologists must be in compliance with the physician regulations of MassHealth.

(4) Ocularists. An ocularist located outside of Massachusetts is eligible to receive payment for vision care services provided to MassHealth members only if the ocularist has been certified by the National Examining Board of Ocularists.

402.405: Nonreimbursable Circumstances

Vision care services are not reimbursable to a vision care provider when the services were furnished in a state institution, in a hospital, or in a hospital-affiliated teaching institution, and when the services are among those for which the provider is compensated by the state or institution.

402.406: Maximum Allowable Fees

The Massachusetts Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for all vision care services and ophthalmic materials, except for those ophthalmic materials purchased through the optical supplier where the basis for the rates is set by the terms of the contract. Payment is always subject to the conditions, exclusions, and limitations set forth in these regulations. The payment for a service will be the lower of the following:

(A) the provider's usual and customary fee; or

(B) the maximum allowable fee listed in the applicable DHCFP fee schedule.

402.407: Individual Consideration

Some services listed in Subchapter 6 of the *Vision Care Manual* are designated "I.C.," an abbreviation for individual consideration. Individual consideration means that a fee could not be established. The payment for an individual-consideration service will be determined by the Division's professional advisors from the provider's descriptive report of the service furnished.

402.408: Prior Authorization

(A) For certain services specified in 130 CMR 402.426 through 402.434, the Division requires that the provider of the service obtain prior authorization as a prerequisite to payment. In addition, services that are designated in Subchapter 6 of the *Vision Care Manual* by the abbreviation "P.A." require prior authorization. These services include but are not limited to:

(1) certain contact lenses;
(2) low-vision aids;
(3) fundus photographs;
(4) unlisted services;
(5) glass lenses;
(6) special-needs glasses;
(7) polycarbonate lenses, except for members who are under age 21 or who are amblyopic or monocular; and
(8) vision training.

(B) Prior authorization requests for low-vision aids for members aged 21 and older must contain a clear statement that the member is diabetic and legally blind.

(C) All prior-authorization requests must be submitted in accordance with the instructions in Subchapter 5 of the *Vision Care Manual*. Prior authorization determines only the health-care necessity of the authorized service and does not establish or waive any other prerequisites for payment such as member eligibility or resort to health insurance payment.

402.409: Separate Procedure

Some procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate identification. When, however, such a procedure is performed independently of, and is not immediately related to, other services, it is designated as a "separate procedure" or "S.P." in the service description. Thus, when a procedure is performed alone for a specific purpose, it must be considered a separate procedure.

(130 CMR 402.410 through 402.415 Reserved)

402.416: Prescription and Dispensing Requirements

(A) Eyeglasses and other visual aids may be dispensed only upon a written and dated prescription. The prescription must be based upon the results of a vision examination performed by the prescriber. The prescription must include all information that is necessary to enable a dispensing practitioner to order the prescription.

(B) The prescriber must provide the member with a signed copy of the prescription without extra charge. The date or dates on which the prescription is filled or refilled must be recorded on the member's copy of the prescription.

(C) The prescriber may order the prescription or may refer the member to another vision care provider.

(D) In order for a dispensing practitioner to be paid for dispensing a prescription involving ophthalmic materials and services available through the optical supplier, all such materials and services must be ordered from the optical supplier. These ophthalmic materials include a specific selection of eyeglass frames for men, women, and children. Members must choose from this selection of frames. Information describing all of the ophthalmic materials and services furnished by the optical supplier is published by the optical supplier under the title "Vision Care Materials" and is distributed to vision care providers by the Division.

(E) In order to receive payment for dispensing an item, the dispensing practitioner must take all necessary measurements, verify lens characteristics, and adjust the completed appliance to the individual. At no additional charge, the dispensing practitioner must continue to make necessary adjustments to the completed appliance for six months after the dispensing date.

(F) The optical supplier will replace free of charge any lens containing any defect or error caused by the optical supplier. Such defects or errors include lenses that are broken, scratched, or chipped at the time of receipt by the dispensing practitioner, or lenses that deviate from the dispensing practitioner's prescription beyond the deviation standards permitted in the American National Standards Institute Z80 rulings. This provision will be effective only if the defective or incorrect lens is received by the optical supplier from the dispensing practitioner within seven working days after the date on which the optical supplier sent the completed order to the dispensing practitioner, and only if it is accompanied by a copy of the original order form containing a notation of the defect or error. In the event of a dispute between the optical supplier and a dispensing practitioner regarding lens deviation, the Division will determine whether the lens in dispute exceeds deviation standards.

(G) Although contractual arrangements are in effect between the Division and the optical supplier, all regulations regarding reimbursable and nonreimbursable services, including prior-authorization requirements, are applicable to all dispensing practitioners.

(H) An order to the optical supplier for prescribed items constitutes a representation by the dispensing practitioner that the person for whom the prescribed item is ordered is an eligible member as of the date of the order. Payment to the optical supplier for items provided pursuant to an order from the dispensing practitioner is chargeable to the dispensing practitioner when the practitioner failed to ascertain member eligibility in accordance with 130 CMR 450.107(B) and with the service limitations in 130 CMR 402.426 through 402.434.

402.417: Recordkeeping Requirements

(A) A vision care provider must maintain a suitable health-care record for each member for a period of at least four years after the date of service. The record must fully disclose all pertinent information regarding the services furnished, including the date of service, the dates on which materials were ordered and dispensed, and a description of materials (including the frame style and the manufacturer's name) ordered and dispensed. All health-care findings resulting from a visual analysis, whether they are normal or abnormal, must be recorded. When extenuating circumstances prevent the use of one or more procedures normally done in a visual analysis, the record must contain the reasons that the tests were not performed.

(B) For comprehensive eye examinations and diagnoses performed in the office, a nursing facility, a hospital, or the member's home, the record must contain the following information or test results:

(1) case history;
(2) visual acuity testing;
(3) ophthalmoscopy and external eye health examination;
(4) ocular mobility testing, heterophoria testing, and fusion testing;
(5) pupillary reflex testing;
(6) refraction (retinoscopy, subjective refraction, and keratometry);
(7) confrontation fields or other screening tests;
(8) tonometry, when medically indicated;
(9) case analysis and disposition; and
(10) biomicroscopy, when medically indicated.

(C) All consultation services must be fully documented in the record. A record for a consultation must contain the following information:

(1) the member's complaints and symptoms;
(2) the condition of the eye; and
(3) if applicable, the name of the person to whom a referral was made.

(D) All screening services must be fully documented in the member's record. A record for a screening service must note the chief complaint and must contain all findings of two or more of the following tests:

(1) distance vision and near vision;
(2) cover test;
(3) visual skills;
(4) tonometry; and
(5) biomicroscopy.

402.418: Services Provided Outside the Office

(A) Member's Home. The Division will pay for vision care services provided to a member in the member's home. A health-care record must be kept on file at the provider's office.

(B) Nursing Facility. The Division will pay an optometrist or an ophthalmologist for performing an eye examination for a member residing in a nursing facility only when the optometrist or ophthalmologist is specifically requested to do so by the medical director, the nursing director, or responsible staff member at the facility, or the member's personal physician. The request must be documented in the member's record at the facility. If eyeglasses are to be dispensed to a member in the facility, the facility must document in the member's record that a consultation has occurred between the facility's staff member and the optometrist or ophthalmologist, and that they have determined that the member is able to benefit from eyeglasses. A copy of the eye-examination results, including the prescription, must be filed in the member's record at the facility and at the optometrist's or ophthalmologist's office.

(C) Other Facilities. The Division will pay for vision care services provided to a member residing in a public or private facility, if payment for these services is not included in the facility's rate. A health-care record must be kept on file at the provider's office.

(D) Claims for Payment.

(1) A visual analysis performed for a member in the member's home, a nursing facility, or another facility must be claimed using the appropriate service codes. (See Subchapter 6 of the *Vision Care Manual*).

(2) The Division will pay once per facility per date of service for the following services: the delivery and adjustment of eyeglasses; the pickup of broken eyeglasses; or the delivery of repaired eyeglasses.

(130 CMR 402.419 through 402.425 Reserved)

402.426: Service Limitations: Visual Analysis

(A)(1) The Division will not pay for a comprehensive eye examination in an optometrist's office or a visual analysis in a home or nursing facility if a comprehensive eye examination or a visual analysis has been furnished:

(a) within the preceding 12 months, for a member under the age of 21; or

(b) within the preceding 24 months, for a member aged 21 or older.

(2) These restrictions do not apply if there is a referral from the member's physician or if one of the following complaints or conditions is documented in the member's record:

(a) blurred vision;

(b) evidence of headaches;

(c) systemic diseases such as diabetes, hyperthyroidism, or HIV;

(d) cataracts;

(e) pain;

(f) redness; or

(g) infection.

(B) The Division will pay for a consultation service only if it is provided independently of a comprehensive eye examination.

(C) The Division will not pay for a screening service if two screening services have been furnished to the member within the preceding 12 months.

(D) A comprehensive eye examination includes a screening service. If the provider performs both a screening service and a comprehensive eye examination for the same member, the Division will pay for only the comprehensive eye exam.

(E) The Division will not pay for a tonometry as a separate service when it is performed as part of a comprehensive eye examination, a consultation, or a screening service. When a tonometry is performed as a separate service to monitor a member who has glaucoma, the provider must use the appropriate service code (see Subchapter 6 of the *Vision Care Manual*).

402.427: Service Limitations: Time and Power Restrictions on Dispensing Eyeglasses

(A) The Division will pay for only one initial pair of eyeglasses and only if there is a corrective power of at least ±.75D sphere or ±.50D cylinder. (See 130 CMR 402.431 for an exception permitting two pairs of eyeglasses instead of bifocals.)

(B) The Division will pay for the replacement of a pair of lost or stolen eyeglasses only if there is a corrective power of at least ±.75D sphere or ±.50D cylinder, and only if the lost or stolen eyeglasses were not dispensed within the preceding 12 months.

(C) The Division will pay for a subsequent pair of lenses only if there is a change from the current prescription of at least ±.50D sphere or cylinder; or an axis change of at least 3º for a ±1.00D cylinder or over, 5º for a ±.75D cylinder, or 10º for a ±.50D cylinder.

402.428: Service Limitations: Broken Eyeglasses

(A) The Division will pay for the repair of broken eyeglasses, including the replacement of broken parts, subject to the following limitations.

(1) No serviceable parts of eyeglass frames supplied by the optical supplier will be replaced.

(2) Except for members under the age of 21, the Division will not pay for the replacement of broken frames and lenses if a repair of either broken frames or lenses was furnished within the preceding 12 months.

(3) Dispensing practitioners must order replacement eyeglass frames, lenses, and repair parts from the optical supplier. Dispensing practitioners must use the order form to obtain replacement parts.

(4) When there is damage to eyeglass frames or lenses that were not fabricated by the optical supplier, dispensing practitioners must adhere to the following procedure:

(a) the member must be instructed to choose a new frame from the selection available through MassHealth; and

(b) using the new frame that has been selected and the member's lens prescription, the dispensing practitioner must order a completely new pair of eyeglasses from the optical supplier.

(5) Payment for dispensing replacement lenses may be claimed under the appropriate service code (see Subchapter 6 of the *Vision Care Manual*) where applicable for the lens being dispensed, but only if each broken lens meets the minimum power criteria for an initial pair of eyeglasses as described in 130 CMR 402.427(A).

(B) The appropriate service codes (see Subchapter 6 of the *Vision Care Manual*) must be used when submitting claims for dispensing replacement frames or parts of frames.

402.429: Service Limitations: Tinted Lenses

(A) The Division will pay for "pink l" and "pink 2" colored lenses, up to 25 percent absorption or equal-density tint, if at least one of the following conditions applies:

(1) the member has a pathological or other abnormal condition such as aphakia; or

(2) the member has habitually worn tinted lenses of this nature, and the prescriber concludes that the member should continue to wear them. The Division will not pay for tinted lenses prescribed only because the member complains of photophobia.

(B) Any condition that warrants the use of tinted lenses must be fully documented in the member's health-care record.

(C) In some situations, other tints (available for plastic lenses only) may be medically justified. Any condition that warrants the use of tinted lenses of this nature must be fully documented in the member's health-care record, and may be ordered from the optical supplier only after the provider has received prior authorization from the Division.

402.430: Service Limitations: Coated Lenses

The Division will pay for coated lenses only when they are needed to give equal-density tint or, using clear coatings only, to prevent excessive reflective glare. Any condition that warrants the use of coated lenses must be fully documented in the member's health-care record.

402.431: Service Limitations: Two Pairs of Eyeglasses Instead of Bifocals

The Division will pay for two pairs of eyeglasses instead of bifocals if one or more of the following conditions exists. Any condition listed below that warrants the use of two pairs of eyeglasses instead of bifocals must be fully documented in the member's health-care record.

(A) The member's prescription cannot satisfactorily be made into bifocal lenses.

(B) The member has shown an inability to adjust to bifocals.

(C) The member has a physical disability (for example, severe arthritis) that would preclude or impede adjustment to bifocals.

(D) The member's advanced age would make adjustment to bifocals unduly difficult.

(E) The member's occupation would make bifocals hazardous.

(F) The member has a marked facial asymmetry.

402.432: Service Limitations: Cataract Lenses

The Division will not pay for glass cataract lenses. All aphakic prescriptions for members requiring cataract lenses must specify plastic lenticular aspheric lenses only. Any condition that warrants the use of cataract lenses must be fully documented in the member's health-care record.

402.433: Service Limitations: Contact Lenses

(A) The Division will pay for hard, soft, or gas-permeable contact lenses if one or more of the following conditions exists:

(1) postoperative cataract extraction;
(2) keratoconus;
(3) anisometropia of more than 3.00D; or
(4) more than 7.00D of myopia or hyperopia.

(B) Any condition that warrants the use of hard, soft, or gas-permeable contact lenses must be fully documented in the member's health-care record.

402.434: Service Limitations: Extra or Spare Eyeglasses

The Division will pay for an extra or spare pair of eyeglasses on a prior-authorization basis only. Any condition that warrants the use of an extra or spare pair of eyeglasses must be fully documented in the member's health-care record. The Division will grant a prior-authorization request for extra or spare eyeglasses only if one or more of the following conditions exists:

(A) aphakia;

(B) more than 7.00D of myopia; or

(C) more than 3.00D of astigma.

402.435: Service Exclusions

(A) The Division will not pay for any of the following services or materials:
(1) absorptive lenses of greater than 25 percent absorption;
(2) prisms obtained by decentration;
(3) treatment of congenital dyslexia (the Massachusetts Department of Education may offer resources for the treatment of this condition);
(4) routine adjustments or follow-up visits to check visual acuity and ocular comfort (payment for such visits is included in the dispensing fee for six months after the date on which the eyeglasses were dispensed);
(5) contact lenses for extended-wear use;
(6) invisible bifocals;
(7) the Welsh 4-Drop Lens; and
(8) substitutions.

(B) (1) If a member desires a substitute for, or a modification of, a reimbursable item, such as designer frames, the member must pay for the entire cost of the eyeglasses, including dispensing fees. The Division will not pay for a portion of the cost of the eyeglasses. In all such instances, the provider must inform the member of the availability of reimbursable items before dispensing nonreimbursable items.
(2) It is unlawful (M.G.L. c. 6A, s. 35) for a provider to accept any payment from a member for a service or item for which payment is available under MassHealth. If a member claims to have been misinformed about the availability of reimbursable items, it will be the responsibility of the provider to prove that the member was offered a reimbursable item, refused it, and chose instead to accept and pay for a nonreimbursable item.

REGULATORY AUTHORITY

130 CMR 402.000: M.G.L. c. 118E, §§ 7 and 12.